

**ASSEMBLY BILL**

**No. 1533**

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**Introduced by Assembly Member Bass**

February 22, 2005

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An act to amend Sections 1357 and 1357.50 of the Health and Safety Code, and to amend Section 10198.6 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1533, as introduced, Bass. Health care coverage.

Existing law governs the licensure and regulation of health care service plans and insurers, and makes a violation of the provisions governing health care service plans a crime. Existing law defines a "late enrollee" as an eligible employee or dependent who has declined health coverage under the health benefit plan offered through employment or sponsored by an employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in that plan. Existing law provides exceptions under which an eligible employee or dependent is not considered a late enrollee.

This bill would add to those exceptions an individual, or his or her dependent, who has lost or will lose Healthy Families Program coverage and who requests enrollment within 30 days after termination of coverage.

Because the bill would change the definition of a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 1357 of the Health and Safety Code is  
2 amended to read:  
3 1357. As used in this article:  
4 (a) *“Dependent” means the spouse or child of an eligible*  
5 *employee, subject to applicable terms of the health care plan*  
6 *contract covering the employee, and includes dependents of*  
7 *guaranteed association members if the association elects to*  
8 *include dependents under its health coverage at the same time it*  
9 *determines its membership composition pursuant to subdivision*  
10 *(o).*  
11 (b) *“Eligible employee” means either of the following:*  
12 (1) Any permanent employee who is actively engaged on a  
13 full-time basis in the conduct of the business of the small  
14 employer with a normal workweek of at least 30 hours, at the  
15 small employer’s regular places of business, who has met any  
16 statutorily authorized applicable waiting period requirements.  
17 The term includes sole proprietors or partners of a partnership, if  
18 they are actively engaged on a full-time basis in the small  
19 employer’s business and included as employees under a health  
20 care plan contract of a small employer, but does not include  
21 employees who work on a part-time, temporary, or substitute  
22 basis. It includes any eligible employee as defined in this  
23 paragraph who obtains coverage through a guaranteed  
24 association. Employees of employers purchasing through a  
25 guaranteed association shall be deemed to be eligible employees  
26 if they would otherwise meet the definition except for the  
27 number of persons employed by the employer. Permanent  
28 employees who work at least 20 hours but not more than 29  
29 hours are deemed to be eligible employees if all four of the  
30 following apply:  
31 (A) They otherwise meet the definition of an eligible  
32 employee except for the number of hours worked.

1 (B) The employer offers the employees health coverage under  
2 a health benefit plan.

3 (C) All similarly situated individuals are offered coverage  
4 under the health benefit plan.

5 (D) The employee must have worked at least 20 hours per  
6 normal workweek for at least 50 percent of the weeks in the  
7 previous calendar quarter. The health care service plan may  
8 request any necessary information to document the hours and  
9 time period in question, including, but not limited to, payroll  
10 records and employee wage and tax filings.

11 (2) Any member of a guaranteed association as defined in  
12 subdivision (o).

13 (c) “In force business” means an existing health benefit plan  
14 contract issued by the plan to a small employer.

15 (d) “Late enrollee” means an eligible employee or dependent  
16 who has declined enrollment in a health benefit plan offered by a  
17 small employer at the time of the initial enrollment period  
18 provided under the terms of the health benefit plan and who  
19 subsequently requests enrollment in a health benefit plan of that  
20 small employer, provided that the initial enrollment period shall  
21 be a period of at least 30 days. It also means any member of an  
22 association that is a guaranteed association as well as any other  
23 person eligible to purchase through the guaranteed association  
24 when that person has failed to purchase coverage during the  
25 initial enrollment period provided under the terms of the  
26 guaranteed association’s plan contract and who subsequently  
27 requests enrollment in the plan, provided that the initial  
28 enrollment period shall be a period of at least 30 days. However,  
29 an eligible employee, any other person eligible for coverage  
30 through a guaranteed association pursuant to subdivision (o), or  
31 *an eligible* dependent shall not be considered a late enrollee if  
32 any of the following is applicable:

33 (1) The individual meets all of the following requirements:

34 (A) He or she was covered under another employer health  
35 benefit plan, *the Healthy Families Program*, or no share-of-cost  
36 Medi-Cal coverage at the time the individual was eligible to  
37 enroll.

38 (B) He or she certified at the time of the initial enrollment that  
39 coverage under another employer health benefit plan, *the Healthy*  
40 *Families Program*, or no share-of-cost Medi-Cal coverage was

1 the reason for declining enrollment, provided that, if the  
2 individual was covered under another employer health plan, the  
3 individual was given the opportunity to make the certification  
4 required by this subdivision and was notified that failure to do so  
5 could result in later treatment as a late enrollee.

6 (C) He or she has lost or will lose coverage under another  
7 employer health benefit plan as a result of termination of  
8 employment of the individual or of a person through whom the  
9 individual was covered as a dependent, change in employment  
10 status of the individual or of a person through whom the  
11 individual was covered as a dependent, termination of the other  
12 plan's coverage, cessation of an employer's contribution toward  
13 an employee or dependent's coverage, death of the person  
14 through whom the individual was covered as a dependent, legal  
15 separation, divorce, *loss of coverage under the Healthy Families*  
16 *Program*, or loss of no share-of-cost Medi-Cal coverage.

17 (D) He or she requests enrollment within 30 days after  
18 termination of coverage or employer contribution toward  
19 coverage provided under another employer health benefit plan.

20 (2) The employer offers multiple health benefit plans and the  
21 employee elects a different plan during an open enrollment  
22 period.

23 (3) A court has ordered that coverage be provided for a spouse  
24 or minor child under a covered employee's health benefit plan.

25 (4) (A) In the case of an eligible employee as defined in  
26 paragraph (1) of subdivision (b), the plan cannot produce a  
27 written statement from the employer stating that the individual or  
28 the person through whom the individual was eligible to be  
29 covered as a dependent, prior to declining coverage, was  
30 provided with, and signed, acknowledgment of an explicit  
31 written notice in boldface type specifying that failure to elect  
32 coverage during the initial enrollment period permits the plan to  
33 impose, at the time of the individual's later decision to elect  
34 coverage, an exclusion from coverage for a period of 12 months  
35 as well as a six-month preexisting condition exclusion, unless the  
36 individual meets the criteria specified in paragraph (1), (2), or  
37 (3).

38 (B) In the case of an association member who did not purchase  
39 coverage through a guaranteed association, the plan cannot  
40 produce a written statement from the association stating that the

1 association sent a written notice in boldface type to all potentially  
2 eligible association members at their last known address prior to  
3 the initial enrollment period informing members that failure to  
4 elect coverage during the initial enrollment period permits the  
5 plan to impose, at the time of the member's later decision to elect  
6 coverage, an exclusion from coverage for a period of 12 months  
7 as well as a six-month preexisting condition exclusion unless the  
8 member can demonstrate that he or she meets the requirements of  
9 subparagraphs (A), (C), and (D) of paragraph (1) or *meets the*  
10 *requirements of* paragraph (2) or (3).

11 (C) In the case of an employer or person who is not a member  
12 of an association, was eligible to purchase coverage through a  
13 guaranteed association, and did not do so, and would not be  
14 eligible to purchase guaranteed coverage unless purchased  
15 through a guaranteed association, the employer or person can  
16 demonstrate that he or she meets the requirements of  
17 subparagraphs (A), (C), and (D) of paragraph (1), or *meets the*  
18 *requirements of* paragraph (2) or (3), or that he or she recently  
19 had a change in status that would make him or her eligible and  
20 that application for enrollment was made within 30 days of the  
21 change.

22 (5) The individual is an employee or dependent who meets the  
23 criteria described in paragraph (1) and was under a COBRA  
24 continuation provision and the coverage under that provision has  
25 been exhausted. For purposes of this section, the definition of  
26 "COBRA" set forth in subdivision (e) of Section 1373.621 shall  
27 apply.

28 (6) The individual is a dependent of an enrolled eligible  
29 employee who has lost or will lose his or her *coverage under the*  
30 *Healthy Families Program* or no share-of-cost Medi-Cal  
31 coverage and requests enrollment within 30 days after  
32 notification of this loss of coverage.

33 (7) The individual is an eligible employee who previously  
34 declined coverage under an employer health benefit plan and  
35 who has subsequently acquired a dependent who would be  
36 eligible for coverage as a dependent of the employee through  
37 marriage, birth, adoption, or placement for adoption, and who  
38 enrolls for coverage under that employer health benefit plan on  
39 his or her behalf; and on behalf of his or her dependent within 30  
40 days following the date of marriage, birth, adoption, or

1 placement for adoption, in which case the effective date of  
2 coverage shall be the first day of the month following the date  
3 the completed request for enrollment is received in the case of  
4 marriage, or the date of birth, or the date of adoption or  
5 placement for adoption, whichever applies. Notice of the special  
6 enrollment rights contained in this paragraph shall be provided  
7 by the employer to an employee at or before the time the  
8 employee is offered an opportunity to enroll in plan coverage.

9 (8) The individual is an eligible employee who has declined  
10 coverage for himself or herself or his or her dependents during a  
11 previous enrollment period because his or her dependents were  
12 covered by another employer health benefit plan at the time of  
13 the previous enrollment period. That individual may enroll  
14 himself or herself or his or her dependents for plan coverage  
15 during a special open enrollment opportunity if his or her  
16 dependents have lost or will lose coverage under that other  
17 employer health benefit plan. The special open enrollment  
18 opportunity shall be requested by the employee not more than 30  
19 days after the date that the other health coverage is exhausted or  
20 terminated. Upon enrollment, coverage shall be effective not  
21 later than the first day of the first calendar month beginning after  
22 the date the request for enrollment is received. Notice of the  
23 special enrollment rights contained in this paragraph shall be  
24 provided by the employer to an employee at or before the time  
25 the employee is offered an opportunity to enroll in plan coverage.

26 (e) “New business” means a health care service plan contract  
27 issued to a small employer that is not the plan’s in force business.

28 (f) “Preexisting condition provision” means a contract  
29 provision that excludes coverage for charges or expenses  
30 incurred during a specified period following the employee’s  
31 effective date of coverage, as to a condition for which medical  
32 advice, diagnosis, care, or treatment was recommended or  
33 received during a specified period immediately preceding the  
34 effective date of coverage.

35 (g) “Creditable coverage” means:

36 (1) Any individual or group policy, contract, or program that is  
37 written or administered by a disability insurer, health care service  
38 plan, fraternal benefits society, self-insured employer plan, or  
39 any other entity, in this state or elsewhere, and that arranges or  
40 provides medical, hospital, and surgical coverage not designed to

1 supplement other private or governmental plans. The term  
2 includes continuation or conversion coverage but does not  
3 include accident only, credit, coverage for onsite medical clinics,  
4 disability income, Medicare supplement, long-term care, dental,  
5 vision, coverage issued as a supplement to liability insurance,  
6 insurance arising out of a workers' compensation or similar law,  
7 automobile medical payment insurance, or insurance under  
8 which benefits are payable with or without regard to fault and  
9 that is statutorily required to be contained in any liability  
10 insurance policy or equivalent self-insurance.

11 (2) The federal Medicare program pursuant to Title XVIII of  
12 the Social Security Act.

13 (3) The medicaid program pursuant to Title XIX of the Social  
14 Security Act.

15 (4) Any other publicly sponsored program, provided in this  
16 state or elsewhere, of medical, hospital, and surgical care.

17 (5) ~~10 U.S.C.A.~~ *U.S.C.* Chapter 55 (commencing with Section  
18 1071) (Civilian Health and Medical Program of the Uniformed  
19 Services (CHAMPUS)).

20 (6) A medical care program of the Indian Health Service or of  
21 a tribal organization.

22 (7) A state health benefits risk pool.

23 (8) A health plan offered under ~~5 U.S.C.A.~~ *U.S.C.* Chapter 89  
24 (commencing with Section 8901) (Federal Employees Health  
25 Benefits Program (FEHBP)).

26 (9) A public health plan as defined in federal regulations  
27 authorized by Section 2701(c)(1)(I) of the Public Health Service  
28 Act, as amended by Public Law 104-191, the Health Insurance  
29 Portability and Accountability Act of 1996.

30 (10) A health benefit plan under Section 5(e) of the Peace  
31 Corps Act (~~22 U.S.C.A.~~ *U.S.C.* Sec. 2504(e)).

32 (11) Any other creditable coverage as defined by subdivision  
33 (c) of Section 2701 of Title XXVII of the federal Public Health  
34 Services Act (42 U.S.C. Sec. 300gg(c)).

35 (h) "Rating period" means the period for which premium rates  
36 established by a plan are in effect and shall be no less than six  
37 months.

38 (i) "Risk adjusted employee risk rate" means the rate  
39 determined for an eligible employee of a small employer in a  
40 particular risk category after applying the risk adjustment factor.

(j) “Risk adjustment factor” means the percentage adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard cost of services. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent.

(k) “Risk category” means the following characteristics of an eligible employee: age, geographic region, and family composition of the employee, plus the health benefit plan selected by the small employer.

(1) No more than the following age categories may be used in determining premium rates:

Under 30

30–39

40–49

50–54

55–59

60–64

65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided by the federal Medicare program pursuant to Title XVIII of the federal Social Security Act.

(2) Small employer health care service plans shall base rates to small employers using no more than the following family size categories:

(A) Single.

(B) Married couple.

(C) One adult and child or children.

(D) Married couple and child or children.

(3) (A) In determining rates for small employers, a plan that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and divide no county into more than two regions. Plans shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state’s population. Geographic regions established pursuant to this section shall, as a group,



1 cover the entire state, and the area encompassed in a geographic  
2 region shall be separate and distinct from areas encompassed in  
3 other geographic regions. Geographic regions may be  
4 noncontiguous.

5 (B) (i) In determining rates for small employers, a plan that  
6 does not operate statewide shall use no more than the number of  
7 geographic regions in the state that is determined by the  
8 following formula: the population, as determined in the last  
9 federal census, of all counties that are included in their entirety in  
10 a plan's service area divided by the total population of the state,  
11 as determined in the last federal census, multiplied by nine. The  
12 resulting number shall be rounded to the nearest whole integer.  
13 No region may be smaller than an area in which the first three  
14 digits of all its ZIP Codes are in common within a county and no  
15 county may be divided into more than two regions. The area  
16 encompassed in a geographic region shall be separate and distinct  
17 from areas encompassed in other geographic regions. Geographic  
18 regions may be noncontiguous. No plan shall have less than one  
19 geographic area.

20 (ii) If the formula in clause (i) results in a plan that operates in  
21 more than one county having only one geographic region, then  
22 the formula in clause (i) shall not apply and the plan may have  
23 two geographic regions, provided that no county is divided into  
24 more than one region.

25 Nothing in this section shall be construed to require a plan to  
26 establish a new service area or to offer health coverage on a  
27 statewide basis, outside of the plan's existing service area.

28 (f) "Small employer" means either of the following:

29 (1) Any person, firm, proprietary or nonprofit corporation,  
30 partnership, public agency, or association that is actively engaged  
31 in business or service, that, on at least 50 percent of its working  
32 days during the preceding calendar quarter or preceding calendar  
33 year, employed at least two, but no more than 50, eligible  
34 employees, the majority of whom were employed within this  
35 state, that was not formed primarily for purposes of buying health  
36 care service plan contracts, and in which a bona fide  
37 employer-employee relationship exists. In determining whether  
38 to apply the calendar quarter or calendar year test, a health care  
39 service plan shall use the test that ensures eligibility if only one  
40 test would establish eligibility. However, for purposes of

subdivisions (a), (b), and (c) of Section 1357.03, the definition shall include employers with at least three eligible employees until July 1, 1997, and two eligible employees thereafter. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association.

(2) Any guaranteed association, as defined in subdivision (n), that purchases health coverage for members of the association.

(m) "Standard employee risk rate" means the rate applicable to an eligible employee in a particular risk category in a small employer group.

(n) "Guaranteed association" means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that (1) includes one or more small employers as defined in paragraph (1) of subdivision (l), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered to the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has included health insurance as a membership benefit for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing

1 board of the association by its members, (8) offers any plan  
2 contract that is purchased to all individual members and  
3 employer members in this state, (9) includes any member  
4 choosing to enroll in the plan contracts offered to the association  
5 provided that the member has agreed to make the required  
6 premium payments, and (10) covers at least 1,000 persons with  
7 the health care service plan with which it contracts. The  
8 requirement of 1,000 persons may be met if component chapters  
9 of a statewide association contracting separately with the same  
10 carrier cover at least 1,000 persons in the aggregate.

11 This subdivision applies regardless of whether a contract  
12 issued by a plan is with an association or a trust formed for, or  
13 sponsored by, an association to administer benefits for  
14 association members.

15 For purposes of this subdivision, an association formed by a  
16 merger of two or more associations after January 1, 1992, and  
17 otherwise meeting the criteria of this subdivision shall be deemed  
18 to have been in active existence on January 1, 1992, if its  
19 predecessor organizations had been in active existence on  
20 January 1, 1992, and for at least five years prior to that date and  
21 otherwise met the criteria of this subdivision.

22 (o) "Members of a guaranteed association" means any  
23 individual or employer meeting the association's membership  
24 criteria if that person is a member of the association and chooses  
25 to purchase health coverage through the association. At the  
26 association's discretion, it also may include employees of  
27 association members, association staff, retired members, retired  
28 employees of members, and surviving spouses and dependents of  
29 deceased members. However, if an association chooses to  
30 include these persons as members of the guaranteed association,  
31 the association shall make that election in advance of purchasing  
32 a plan contract. Health care service plans may require an  
33 association to adhere to the membership composition it selects  
34 for up to 12 months.

35 (p) "Affiliation period" means a period that, under the terms of  
36 the health care service plan contract, must expire before health  
37 care services under the contract become effective.

38 SEC. 2. Section 1357.50 of the Health and Safety Code is  
39 amended to read:

40 1357.50. For purposes of this article:

(a) “Health benefit plan” means any individual or group insurance policy or health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) “Late enrollee” means an eligible employee or dependent who has declined health coverage under a health benefit plan offered through employment or sponsored by an employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that employer, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee or dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) The individual was covered under another employer health benefit plan, *the Healthy Families Program*, or no share-of-cost Medi-Cal coverage at the time the individual was eligible to enroll.

(B) The individual certified, at the time of the initial enrollment, that coverage under another employer health benefit plan, *the Healthy Families Program*, or no share-of-cost Medi-Cal coverage was the reason for declining enrollment provided that, if the individual was covered under another employer health benefit plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) The individual has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the

individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of a person through whom the individual was covered as a dependent, legal separation, divorce, *loss of coverage under the Healthy Families Program*, or loss of no share-of-cost Medi-Cal coverage.

(D) The individual requests enrollment within 30 days after termination of coverage, or cessation of employer contribution toward coverage provided under another employer health benefit plan.

(2) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan. The health benefit plan shall enroll a dependent child within 30 days after receipt of a court order or request from the district attorney, either parent or the person having custody of the child as defined in Section 3751.5 of the Family Code, the employer, or the group administrator. In the case of children who are eligible for medicaid, the State Department of Health Services may also make the request.

(4) The plan cannot produce a written statement from the employer stating that, prior to declining coverage, the individual or the person through whom the individual was eligible to be covered as a dependent was provided with, and signed acknowledgment of, explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion, unless the individual meets the criteria specified in paragraph (1), (2), or (3).

(5) The individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision, and the coverage under that provision has been exhausted. For purposes of this section, the definition of "COBRA" set forth in subdivision (e) of Section 1373.621 shall apply.

1 (6) The individual is a dependent of an enrolled eligible  
2 employee who has lost or will lose his or her *coverage under the*  
3 *Healthy Families Program* or no share-of-cost Medi-Cal  
4 coverage and requests enrollment within 30 days of notification  
5 of this loss of coverage.

6 (7) The individual is an eligible employee who previously  
7 declined coverage under an employer health benefit plan and  
8 who has subsequently acquired a dependent who would be  
9 eligible for coverage as a dependent of the employee through  
10 marriage, birth, adoption, or placement for adoption, and who  
11 enrolls for coverage under that employer health benefit plan on  
12 his or her behalf, and on behalf of his or her dependent within 30  
13 days following the date of marriage, birth, adoption, or  
14 placement for adoption, in which case the effective date of  
15 coverage shall be the first day of the month following the date  
16 the completed request for enrollment is received in the case of  
17 marriage, or the date of birth, or the date of adoption or  
18 placement for adoption, whichever applies. Notice of the special  
19 enrollment rights contained in this paragraph shall be provided  
20 by the employer to an employee at or before the time the  
21 employee is offered an opportunity to enroll in plan coverage.

22 (8) The individual is an eligible employee who has declined  
23 coverage for himself or herself or his or her dependents during a  
24 previous enrollment period because his or her dependents were  
25 covered by another employer health benefit plan at the time of  
26 the previous enrollment period. That individual may enroll  
27 himself or herself or his or her dependents for plan coverage  
28 during a special open enrollment opportunity if his or her  
29 dependents have lost or will lose coverage under that other  
30 employer health benefit plan. The special open enrollment  
31 opportunity shall be requested by the employee not more than 30  
32 days after the date that the other health coverage is exhausted or  
33 terminated. Upon enrollment, coverage shall be effective not  
34 later than the first day of the first calendar month beginning after  
35 the date the request for enrollment is received. Notice of the  
36 special enrollment rights contained in this paragraph shall be  
37 provided by the employer to an employee at or before the time  
38 the employee is offered an opportunity to enroll in plan coverage.

39 (c) "Preexisting condition provision" means a contract  
40 provision that excludes coverage for charges or expenses

1 incurred during a specified period following the enrollee's  
2 effective date of coverage, as to a condition for which medical  
3 advice, diagnosis, care, or treatment was recommended or  
4 received during a specified period immediately preceding the  
5 effective date of coverage.

6 (d) "Creditable coverage" means:

7 (1) Any individual or group policy, contract, or program that is  
8 written or administered by a disability insurance company,  
9 nonprofit hospital service plan, health care service plan, fraternal  
10 benefits society, self-insured employer plan, or any other entity,  
11 in this state or elsewhere, and that arranges or provides medical,  
12 hospital and surgical coverage not designed to supplement other  
13 private or governmental plans. The term includes continuation or  
14 conversion coverage but does not include accident only, credit,  
15 coverage for onsite medical clinics, disability income, Medicare  
16 supplement, long-term care insurance, dental, vision, coverage  
17 issued as a supplement to liability insurance, insurance arising  
18 out of a workers' compensation or similar law, automobile  
19 medical payment insurance, or insurance under which benefits  
20 are payable with or without regard to fault and that is statutorily  
21 required to be contained in any liability insurance policy or  
22 equivalent self-insurance.

23 (2) The federal Medicare program pursuant to Title XVIII of  
24 the Social Security Act.

25 (3) The medicaid program pursuant to Title XIX of the Social  
26 Security Act.

27 (4) Any other publicly sponsored program, provided in this  
28 state or elsewhere, of medical, hospital and surgical care.

29 (5) ~~10 U.S.C.A.~~ *U.S.C.* Chapter 55 (commencing with Section  
30 1071) (Civilian Health and Medical Program of the Uniformed  
31 Services (CHAMPUS)).

32 (6) A medical care program of the Indian Health Service or of  
33 a tribal organization.

34 (7) A state health benefits risk pool.

35 (8) A health plan offered under ~~5 U.S.C.A.~~ *U.S.C.* Chapter 89  
36 (commencing with Section 8901) (Federal Employees Health  
37 Benefits Program (FEHBP)).

38 (9) A public health plan as defined in federal regulations  
39 authorized by Section 2701(c)(1)(I) of the Public Health Service

1 Act, as amended by Public Law 104-191, the Health Insurance  
2 Portability and Accountability Act of 1996.

3 (10) A health benefit plan under Section 5(e) of the Peace  
4 Corps Act (22 ~~U.S.C.A.~~ *U.S.C.* Sec. 2504(e)).

5 (11) Any other creditable coverage as defined by subdivision  
6 (c) of Section 2701 of Title XXVII of the federal Public Health  
7 Services Act (42 U.S.C. Sec. 300gg(c)).

8 (e) “Waivered condition” means a contract provision that  
9 excludes coverage for charges or expenses incurred during a  
10 specified period of time for one or more specific, identified,  
11 medical conditions.

12 (f) “Affiliation period” means a period that, under the terms of  
13 the health benefit plan, must expire before health care services  
14 under the plan become effective.

15 SEC. 3. Section 10198.6 of the Insurance Code is amended to  
16 read:

17 10198.6. For purposes of this article:

18 (a) “Health benefit plan” means any group or individual policy  
19 or contract that provides medical, hospital, or surgical benefits.  
20 The term does not include accident only, credit, disability  
21 income, coverage of Medicare services pursuant to contracts with  
22 the United States government, Medicare supplement, long-term  
23 care insurance, dental, vision, coverage issued as a supplement to  
24 liability insurance, insurance arising out of a workers’  
25 compensation or similar law, automobile medical payment  
26 insurance, or insurance under which benefits are payable with or  
27 without regard to fault and that is statutorily required to be  
28 contained in any liability insurance policy or equivalent  
29 self-insurance.

30 (b) “Late enrollee” means an eligible employee or dependent  
31 who has declined health coverage under a health benefit plan  
32 offered through employment or sponsored by an employer at the  
33 time of the initial enrollment period provided under the terms of  
34 the health benefit plan, and who subsequently requests  
35 enrollment in a health benefit plan of that employer; provided  
36 that the initial enrollment period shall be a period of at least 30  
37 days. However, an eligible employee or dependent shall not be  
38 considered a late enrollee if any of the following is applicable:

39 (1) The individual meets all of the following requirements:



1 (A) The individual was covered under another employer health  
2 benefit plan, *the Healthy Families Program*, or no share-of-cost  
3 Medi-Cal coverage at the time the individual was eligible to  
4 enroll.

5 (B) The individual certified, at the time of the initial  
6 enrollment that coverage under another employer health benefit  
7 plan, *the Healthy Families Program*, or no share-of-cost  
8 Medi-Cal coverage was the reason for declining enrollment  
9 provided that, if the individual was covered under another  
10 employer health benefit plan, the individual was given the  
11 opportunity to make the certification required by this subdivision  
12 and was notified that failure to do so could result in later  
13 treatment as a late enrollee.

14 (C) The individual has lost or will lose coverage under another  
15 employer health benefit plan as a result of termination of  
16 employment of the individual or of a person through whom the  
17 individual was covered as a dependent, change in employment  
18 status of the individual or of a person through whom the  
19 individual was covered as a dependent, termination of the other  
20 plan's coverage, cessation of an employer's contribution toward  
21 an employee or dependent's coverage, death of a person through  
22 whom the individual was covered as a dependent, legal  
23 separation, divorce, *loss of coverage under the Healthy Families*  
24 *Program*, or loss of no share-of-cost Medi-Cal coverage.

25 (D) The individual requests enrollment within 30 days after  
26 termination of coverage, or cessation of employer contribution  
27 toward coverage provided under another employer health benefit  
28 plan.

29 (2) The individual is employed by an employer that offers  
30 multiple health benefit plans and the individual elects a different  
31 plan during an open enrollment period.

32 (3) A court has ordered that coverage be provided for a spouse  
33 or minor child under a covered employee's health benefit plan.

34 (4) The carrier cannot produce a written statement from the  
35 employer stating that, prior to declining coverage, the individual  
36 or the person through whom the individual was eligible to be  
37 covered as a dependent was provided with, and signed  
38 acknowledgment of, explicit written notice in boldface type  
39 specifying that failure to elect coverage during the initial  
40 enrollment period permits the carrier to impose, at the time of the

1 individual's later decision to elect coverage, an exclusion from  
2 coverage for a period of 12 months as well as a six-month  
3 preexisting condition exclusion, unless the individual meets the  
4 criteria specified in paragraph (1), (2), or (3).

5 (5) The individual is an employee or dependent who meets the  
6 criteria described in paragraph (1) and was under a COBRA  
7 continuation provision and the coverage under that provision has  
8 been exhausted. For purposes of this section, the definition of  
9 "COBRA" set forth in subdivision (e) of Section 10116.5 shall  
10 apply.

11 (6) The individual is a dependent of an enrolled eligible  
12 employee who has lost or will lose his or her *coverage under the*  
13 *Healthy Families Program* or no share-of-cost Medi-Cal  
14 coverage and requests enrollment within 30 days of notification  
15 of this loss of coverage.

16 (c) "Preexisting condition provision" means a policy provision  
17 that excludes coverage for charges or expenses incurred during a  
18 specified period following the insured's effective date of  
19 coverage, as to a condition for which medical advice, diagnosis,  
20 care, or treatment was recommended or received during a  
21 specified period immediately preceding the effective date of  
22 coverage.

23 (d) "Creditable coverage" means:

24 (1) Any individual or group policy, contract or program, that is  
25 written or administered by a disability insurance company, health  
26 care service plan, fraternal benefits society, self-insured  
27 employer plan, or any other entity, in this state or elsewhere, and  
28 that arranges or provides medical, hospital, and surgical coverage  
29 not designed to supplement other private or governmental plans.  
30 The term includes continuation or conversion coverage but does  
31 not include accident only, credit, coverage for onsite medical  
32 clinics, disability income, Medicare supplement, long-term care  
33 insurance, dental, vision, coverage issued as a supplement to  
34 liability insurance, insurance arising out of a workers'  
35 compensation or similar law, automobile medical payment  
36 insurance, or insurance under which benefits are payable with or  
37 without regard to fault and that is statutorily required to be  
38 contained in any liability insurance policy or equivalent  
39 self-insurance.

1 (2) The federal Medicare program pursuant to Title XVIII of  
2 the Social Security Act.

3 (3) The medicaid program pursuant to Title XIX of the Social  
4 Security Act.

5 (4) Any other publicly sponsored program, provided in this  
6 state or elsewhere, of medical, hospital and surgical care.

7 (5) ~~10 U.S.C.A.~~ U.S.C. Chapter 55 (commencing with Section  
8 1071) (Civilian Health and Medical Program of the Uniformed  
9 Services (CHAMPUS)).

10 (6) A medical care program of the Indian Health Service or of  
11 a tribal organization.

12 (7) A state health benefits risk pool.

13 (8) A health plan offered under ~~5 U.S.C.A.~~ U.S.C. Chapter 89  
14 (commencing with Section 8901) (Federal Employees Health  
15 Benefits Program (FEHBP)).

16 (9) A public health plan as defined in federal regulations  
17 authorized by Section 2701(c)(1)(I) of the Public Health Service  
18 Act, as amended by Public Law 104-191, the Health Insurance  
19 Portability and Accountability Act of 1996.

20 (10) A health benefit plan under Section 5(e) of the Peace  
21 Corps Act (~~22 U.S.C.A.~~ U.S.C. Sec. 2504(e)).

22 (11) Any other creditable coverage as defined by subsection  
23 (c) of Section 2701 of Title XXVII of the federal Public Health  
24 Services Act (42 U.S.C. Sec. 300gg(c)).

25 (e) "Affiliation period" means a period that, under the terms of  
26 the health benefit plan, must expire before health care services  
27 under the plan become effective.

28 (f) "Waivered condition" means a contract provision that  
29 excludes coverage for charges or expenses incurred during a  
30 specified period of time for one or more specific, identified,  
31 medical conditions.

32 SEC. 4. No reimbursement is required by this act pursuant to  
33 Section 6 of Article XIII B of the California Constitution because  
34 the only costs that may be incurred by a local agency or school  
35 district will be incurred because this act creates a new crime or  
36 infraction, eliminates a crime or infraction, or changes the  
37 penalty for a crime or infraction, within the meaning of Section  
38 17556 of the Government Code, or changes the definition of a  
39 crime within the meaning of Section 6 of Article XIII B of the  
40 California Constitution.

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